DRUG COURT PARTNERSHIP QUARTERLY REIMBURSEMENT CLAIM

Check here if this is a revised claim ☐	PROJECT BUDGET PERIOD: From ____/____/____ To:____/____/____ BILLING PERIOD COVERED BY THIS CLAIM: From ____/____/____ To:____/____/____	County:_____ Grant Award #_____ Grantee:_____ (County Agency identified as Grantee on the Notice of Grant Award) Address:_____ City/Zip: _____ Phone: _____ Email Address:_____	**Mail Completed Form To:** **Department of Alcohol & Drug Programs** **Office of Drug Court Programs** **DCP Program Coordinator** **1700 K Streets, 5th Floor** **Sacramento, CA 95814-4022**

Important Notes: *1.) Quarterly Narrative Reports must be submitted with this invoice for payment to be processed. 2.) Refer to your Terms and Conditions as to the quarterly claims and narrative report.*

Section I. Treatment Related Costs: Budget and Current Expenditures (Do not include court related/other costs)

A	B	C	D	E	F	H	I
BUDGET LINE ITEMS	**Budget**	**Beginning Balance**	**Budget Line Item Change (Justification Required)**	**Treatment Related Costs**	**Ending Balance (Do not include Match Amount) (Columns C+D-E=F)**	**20 Percent Match Requirement This Quarter**	**Cumulative**
Personnel	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fringe Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Contractual Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Indirect Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL SECTION I	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -

Section II. Court Related/Other Costs: Budget and Current Expenditures (Do not include treatment related costs)

BUDGET LINE ITEMS	**Budget**	**Beginning Balance**	**Budget Line Item Change (Justification Required)**	**Court Related/Other Costs**	**Ending Balance (Do not include Match Amount) (Columns C+D-E=F)**	**20 Percent Match Requirement This Quarter**	**Cumulative**
Personnel	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fringe Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Admin Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Contractual Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Indirect Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL SECTION II	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GRAND TOTAL OF SECTIONS I AND II	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Section III. CERTIFICATION [*(Please sign in BLUE ink)* **Reimbursement will not be approved unless a copy of this quarter's NARRATIVE REPORT IS ATTACHED.]** *County Alcohol and Other Drug (AOD) Program Administrator's certification that all expenditures claimed above are consistent with the requirements of the county's grant award and that a copy of this quarter's narrative report is attached.*

X _____ Date: _____/_____/_____ _____

AOD Administrator's Signature **Please print the name of the Administrator**

Department of Alcohol and Drug Programs Office of Drug Court Programs Use Only

I hereby certify that the required reports for the above billing period have been received. The fiscal data contained in this invoice has been recorded and submitted to ADP's Accounting Office

_____ Date: _____/_____/_____ _____

Drug Court Partnership Program Coordinator Signature **Please print the name of the Coodinator**

ADP Accounting Section Use Only

TC Number : FY: PCA Number:

Vendor Number: Grant: